UNPUBLISHED

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF IOWA
CEDAR RAPIDS DIVISION

CLAUDE B. CHARETTE, Plaintiff, vs. JOHN DUFFY and JERRY CONNOLLY, Defendants.	No. C03-0023-MWB **REPORT AND RECOMMENDATION ON MOTION FOR SUMMARY JUDGMENT**

TABLE OF CONTENTS

I. INTRODUCTION 1

II. STANDARDS FOR SUMMARY JUDGMENT 3

III. MATERIAL FACTS 5

IV. ANALYSIS 26

A. Charette's Eighth Amendment Claim 26

B. The Defendants' Other Grounds for Summary Judgment 35

V. CONCLUSION 35

I. INTRODUCTION

This matter is before the court on the defendants' motion for summary judgment, filed September 26, 2003. (Doc. No. 25) The plaintiff Claude B. Charette ("Charette") resisted the motion on March 3, 2004. (Doc. No. 39) The defendants filed a reply brief on July 2, 2004. (Doc. No. 48) The plaintiff filed a surreply on July 26, 2004. (Doc.

No. 51) By order dated May 29, 2003 (Doc. No. 15), this matter was referred to the undersigned United States Magistrate Judge for the issuance of a report and recommended disposition.

A former inmate of the Anamosa State Penitentiary in Anamosa, Iowa, Charette filed this action against the defendants under 42 U.S.C. § 1983 to redress the alleged deprivation of his constitutional rights. (*See* Doc. No. 12) Charette contends the defendants violated his Eighth Amendment rights by being deliberately indifferent to his serious medical needs.[1] (*Id.*) Specifically, Charette alleges the defendants failed to provide him with proper testing, treatment, and care for Hepatitis C. (*Id.*) For the alleged violation of his constitutional rights, Charette seeks compensatory damages, punitive damages, reasonable attorney fees, interest at the maximum legal rate, court costs, and such other and further relief as the court deems equitable and just. (*Id.*)

The defendants deny they committed any constitutional violation. They maintain there are no disputed material facts and they are entitled to judgment as a matter of law. (*See* Doc. No. 25) Specifically, the defendants argue Charette has failed to state an Eighth Amendment claim for which relief can be granted, and his claim is barred by 42 U.S.C. § 1997e(e). (*Id.*) Alternatively, the defendants argue they are entitled to qualified immunity. (*Id.*)

Finding the motion for summary judgment to be fully submitted and ready for decision, the court turns now to consideration of the defendants' motion.

---

[1] The Eighth Amendment to the United States Constitution provides that "[e]xcessive bail shall not be required, nor excessive fines imposed, nor cruel and unusual punishments inflicted." U.S. Const., amend. VIII. The Eighth Amendment is applicable to the states through the Fourteenth Amendment. *Rhodes v. Chapman*, 452 U.S. 337, 344-45, 101 S. Ct. 2392, 2398, 69 L. Ed. 2d 59 (1981).

II. STANDARDS FOR SUMMARY JUDGMENT

Rule 56 of the Federal Rules of Civil Procedure governs motions for summary judgment and provides that either party to a lawsuit may move for summary judgment without the need for supporting affidavits. *See* Fed. R. Civ. P. 56(a), (b). Rule 56 further states that summary judgment:

> shall be rendered forthwith if the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is entitled to judgment as a matter of law.

Fed. R. Civ. P. 56(c). A court considering a motion for summary judgment "must view all of the facts in the light most favorable to the nonmoving party and give that party the benefit of all reasonable inferences that can be drawn from the facts." *Webster Indus., Inc. v. Northwood Doors, Inc.*, 320 F. Supp. 2d 821, 828 (N.D. Iowa 2004) (citing *Matsushita Elec. Indus. Co. v. Zenith Radio Corp.*, 475 U.S. 574, 587, 106 S. Ct. 1348, 1356, 89 L. Ed. 2d 538 (1986); and *Quick v. Donaldson Co.*, 90 F.3d 1372, 1376-77 (8th Cir. 1996)).

The party seeking summary judgment must "'inform[ ] the district court of the basis for [the] motion and identify[ ] those portions of the record which show lack of a genuine issue.'" *Webster Indus.*, 320 F. Supp. 2d at 829 (quoting *Hartnagel v. Norman*, 953 F.2d 394, 395 (8th Cir. 1992), in turn citing *Celotex Corp. v. Catrett*, 477 U.S. 317, 323, 106 S. Ct. 2548, 2552-53, 91 L. Ed. 2d 265 (1986)). A genuine issue of material fact is one with a real basis in the record. *Id.* (citing *Hartnagel*, 953 F.2d at 394, in turn citing *Matsushita*, 475 U.S. at 586-87, 106 S. Ct. at 1356). Once the moving party meets its initial burden under Rule 56 of showing there is no genuine issue of material fact, the nonmoving party, "by affidavits or as otherwise provided in [Rule 56], must set forth specific facts showing that there is a genuine issue for trial." Fed. R. Civ. P. 56(e); *see*

Webster Indus, 320 F. Supp. 2d at 829 (citing, *inter alia*, *Celotex*, 477 U.S. at 324, 106 S. Ct. at 2553; and *Rabushka ex rel. United States v. Crane Co.*, 122 F.3d 559, 562 (8th Cir. 1997)).

Addressing the quantum of proof necessary to successfully oppose a motion for summary judgment, the Supreme Court has explained that the nonmoving party must produce sufficient evidence to permit "a reasonable jury [to] return a verdict for the nonmoving party." *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 248, 106 S. Ct. 2505, 2510, 91 L. Ed. 2d 202 (1986). Furthermore, the Supreme Court has held the trial court must dispose of claims unsupported by fact and determine whether a genuine issue exists for trial, rather than weighing the evidence and determining the truth of the matter. *See Anderson*, 477 U.S. at 249, 106 S. Ct. at 2510; *Celotex*, 477 U.S. at 323-24, 106 S. Ct. at 2552-53; *Matsushita*, 475 U.S. at 586-87, 106 S. Ct. at 1356.

The Eighth Circuit recognizes that "summary judgment is a drastic remedy and must be exercised with extreme care to prevent taking genuine issues of fact away from juries." *Wabun-Inini v. Sessions*, 900 F.2d 1234, 1238 (8th Cir. 1990) (citing Fed. R. Civ. P. 56(c)). The Eighth Circuit, however, also follows the principle that "summary judgment procedure is properly regarded not as a disfavored procedural shortcut, but rather as an integral part of the Federal Rules as a whole, which are designed 'to secure the just, speedy and inexpensive determination of every action.'" *Id.* (quoting *Celotex*, 477 U.S. at 327, 106 S. Ct. at 2555); *see also Hartnagel*, 953 F.2d at 396.

Thus, the trial court must assess whether a nonmovant's response would be sufficient to carry the burden of proof at trial. *Hartnagel*, 953 F.2d at 396 (citing *Celotex*, 477 U.S. at 322, 106 S. Ct. at 2552). If the nonmoving party fails to make a sufficient showing of an essential element of a claim with respect to which it has the burden of proof, then the moving party is "entitled to judgment as a matter of law." *Celotex*, 477 U.S. at

323, 106 S. Ct. at 2552; *Woodsmith Pub. Co. v. Meredith Corp.*, 904 F.2d 1244, 1247 (8th Cir. 1990). However, if the court can conclude that a reasonable jury could return a verdict for the nonmovant, then summary judgment should not be granted. *Anderson*, 477 U.S. at 248, 106 S. Ct. at 2510; *Burk v. Beene*, 948 F.2d 489, 492 (8th Cir. 1991); *Woodsmith*, 904 F.2d at 1247.

III. MATERIAL FACTS[2]

On January 12, 1995, Charette was committed to the custody and care of the Iowa Department of Corrections and ordered to serve a ten-year sentence. On the same date, Charette was transported to the Iowa Medical and Classification Center in Oakdale, Iowa ("IMCC"). During intake testing at IMCC, Charette tested positive for the Hepatitis C antibody. Initial orders from medical practitioners placed Charette on Infectious Disease Protocol, and identified Hepatitis C as a major problem. Per protocol, officials ordered a repeat liver function test for Charette in six months. On March 16, 1995, Charette was transferred to the Anamosa State Penitentiary ("ASP"). While he was confined at ASP, Charette was under the medical care of the defendant Dr. John Duffy, a medical doctor, and the defendant Jerry Connolly ("Connolly"), the director of nursing services at ASP.

On July 18, 1995, Dr. Duffy talked to Charette about the possibility of participating in an experimental treatment program for inmates with Hepatitis C, to be administered by the University of Iowa Hospitals and Clinics-Digestive Disease Clinic ("UIHC"). After Dr. Duffy explained the possible side effects and likelihood of success, Charette declined to participate in the treatment program. At the defendants' request, Charette signed a form

[2]Except where noted otherwise, the following facts were taken from the defendants' statement of material facts (Doc. No. 25-3) and appendix (Doc. No. 25-4), and Charette's affidavit (Doc. No. 39-3) and statement of material facts (Doc. No. 39-4).

refusing the treatment, and Dr. Duffy discontinued further testing for Charette's Hepatitis C. Dr. Duffy spoke with Charette about the program again on July 27, 1995, and Charette still declined to participate in the program.

In October 1995, Charette was evaluated at ASP by a Dr. Bahock for a separate injury. At that time, a repeat liver function test was completed and it showed continued abnormalities. On November 11, 1995, Dr. Bahock talked with Charette about the test results, and Charette continued to decline to participate in the experimental program. In addition, Charette told the doctor he planned to resume consuming alcohol as soon as he was released from custody.

On or about December 6, 1999, Charette reported to Dr. Duffy that his urine was unusually dark, and he was experiencing abdominal pain in his right upper quadrant. On December 7, 1999, Charette asked that the medical treatment refusal form be rescinded, and that he be treated for his Hepatitis C. He also requested a liver biopsy. Dr. Duffy ordered repeat lab tests. The parties differ on the results of the lab tests. Charette states the tests indicated an elevated liver enzyme level, while Dr. Duffy states the tests indicated an improvement in Charette's overall liver function. Based on his interpretation of the tests, Dr. Duffy ordered follow-up liver function testing in six months. In January of 2000, Dr. Duffy reviewed Charette's December 1999 liver function tests in response to Charette's request for a liver biopsy. Dr. Duffy determined Charette did not qualify for further evaluation through the UIHC's experimental treatment program, which required test results to be 4 to 5 times above baseline lab results on two occasions, at a minimum of thirty days apart. Dr. Duffy therefore ordered that Charette's treatment plan continue without change, including periodic monitoring of liver function tests and physical examinations by ASP staff.

On July 11, 2000, Charette asked to see a specialist and to be given a liver biopsy, but his request was denied. On August 8, 2000, Charette filed a grievance against Connolly and Dr. Duffy, alleging they had denied him the proper medical care and treatment for his Hepatitis C.[3] In the grievance, Charette asked to see a specialist at the UIHC so he could receive testing and treatment. On August 14, 2000, Connolly responded to Charette's grievance, stating as follows:

> This individual has voiced concern regarding the treatment of his Hepatitis C. He is of the belief that he needs to be evaluated by a specialist in the hepatitis or liver field. This individual's Hepatitis C status was last reviewed on July 11, 2000. At that time, Dr. Duffy[] note[d] . . . that he does not fit the criteria for Hepatitis C treatment. This individual's Hepatitis C status will continue to be monitored as per Department Policy. . . .

(Doc. No. 4, p. 15)

On August 25, 2000, a grievance officer denied Charette's grievance. On August 29, 2000, Charette appealed the denial of his grievance. On September 6, 2000, the warden denied Charette's appeal, holding as follows:

> I concur with the findings of [the grievance officer]. Department of Corrections Health Policies are being followed here and you are being monitored by our health professionals. I must defer to their medical judgment as no policy is being violated. . . .

(Doc. No. 4, p. 18)

[3] Facts in this paragraph and the following paragraph are taken from Charette's Complaint (Doc. No. 4), at pages 12-21, and Charette's affidavit (Doc. No. 39-3), at pages 4-6. Thereafter, the facts again are taken from the defendants' statement of material facts (Doc. No. 25-3) and appendix (Doc. No. 25-4), and Charette's affidavit (Doc. No. 39-3) and statement of material facts (Doc. No. 39-4).

On September 11, 2000, Charette appealed the warden's decision to the Director of the Iowa Department of Corrections ("DOC"). On January 25, 2001, a grievance officer for the Iowa DOC denied Charette's appeal, noting the DOC was following evaluation criteria established by the DOC's Medical Director, in conjunction with the UIHC, and Charette did not meet the criteria for referral.

In order to insure that he properly exhausted his administrative remedies, Charette contacted the University of Iowa Clinical Law Program (the "CLP") in March of 2001. After obtaining Charette's medical records, the CLP concluded that Charette qualified for a liver biopsy. On April 17, 2001, the CLP wrote to Charette regarding its determination.

On August 14, 2001, Charette was transferred to the Mount Pleasant Correctional Facility, where he remained until March 26, 2002. He then was returned to ASP. While at the Mount Pleasant Correctional Facility, Charette continued to have his Hepatitis C status monitored.

On December 4, 2001, the CLP contacted the office of the Iowa Attorney General and requested that Charette receive treatment for his condition. On February 1, 2002, the CLP informed Charette that additional medical records had been received. On August 8, 2002, the CLP wrote a letter to Dr. Harbans Deol, the DOC Medical Director, and requested that the denial of medical care be remedied.

On August 22, 2002, Dr. Deol directed Dr. Duffy to refer Charette to the UIHC for further evaluation of his Hepatitis C. On November 6, 2002, Charette learned that an appointment had been scheduled at the UIHC's Digestive Disease Clinic. The parties dispute the results of Charette's liver function testing during this time period. The defendants claim that by August 2002, Charette's liver function studies had "returned to essentially within normal limits." (Doc. No. 25-3, ¶ 9). Charette claims testing in both

March and October 2002 indicated levels that were above normal (1.53 times normal in March, and 1.07 times normal in October).

On January 16, 2003, the Iowa Department of Corrections updated its health services policy regarding Hepatitis. The new policy provides, in relevant part, as follows:

> Inmates with objective data supporting a diagnosis (major problem) of infectious hepatitis require monitoring of their clinical condition, liver function, and infectious status consistent with data documented in the inmate's health record. Inmates found to have chronic Hepatitis C should have liver function studies at least every six months as well as medical practitioner examination for presence of possible liver disease. Criteria for treatment of HCV infection has been established in conjunction with UIHC Liver Clinic. Patients who have elevated ALTs on three different testing dates -- over a period of two to six months -- should be referred to Hepatitis C Committee for treatment recommendations set forth in accordance to specific guidelines outlined in the Hep C Management plan. Patients who meet eligibility criteria will then be referred to UIHC Liver Clinic for consultations. Eligibility and ineligibility criteria, protocol for liver biopsy, consent for treatment and treatment plan sheets are outlined in the Hep C Management Plan guide and pathway. . . .

(Doc. No. 39-3, p. 21) Listed among the eligibility criteria are the following:

> Liver Enzyme Elevations: Greater than 1.5 times normal on three occasions over a 6 month period (initial abnormal lab, then at 3 and 6 months).
> Persistent enzyme elevation is an indicator of ongoing liver disease. . . .

(*Id.*, p. 22)

On February 7, 2003, Charette was examined at the UIHC by Stephanie Dee, a physician's assistant. PA Dee recommended Charette undergo an ultrasound and a liver

biopsy. On February 11, 2003, PA Dee wrote a letter to Dr. Duffy regarding Charette's examination and treatment recommendations, stating, in part, as follows::

> Mr. Charette was referred to the Liver Clinic for evaluation of his Hepatitis C. He has a history of a positive Hepatitis C antibody and elevated ALT. I discussed with him the natural history, prognosis, and potential treatment options available for Hepatitis C. In order to determine the extent of disease, he will be scheduled to return for an ultrasound and a liver biopsy. Additional lab work will be obtained to further characterize the Hepatitis C and rule out other autoimmune and metabolic disorders. I will plan to see him back in clinic approximately two weeks following the biopsy to further discuss the results.

(Doc. No. 39-3, p. 9, ¶ 32)

On April 21, 2003, a liver function test revealed that Charette's liver enzyme levels were within normal limits. Dr. Duffy reported the results to Connolly, and told Connolly that Charette's liver biopsy could not be scheduled until May of 2003. Dr. Duffy advised Dr. Deol that Charette's recent liver enzyme test was normal, and his ALT had not been over 90 (1.5 x normal) since March 13, 2002, but his ALT results were very different when Charette was seen at the UIHC on February 7, 2003, leading the UIHC to suggest an ultrasound and a liver biopsy. Dr. Duffy's April 24, 2003, medical progress notes indicate that Dr. Deol advised him to monitor Charette per department protocol, order three liver function tests and liver checks to be performed within six months, and then re-evaluate Charette pursuant to the DOC's Hepatitis C protocol to see if he qualified for further treatment for his Hepatitis C. The prescribed treatment plan would require an evaluation of Charette's lab results in October of 2003, by a medical doctor at ASP. Dr. Duffy canceled Charette's follow-up appointment and testing at the UIHC. Charette's July 2003 liver function tests all were within normal limits.

Charette consulted Diana E. Bohlke, R.N., and asked for her expert medical opinion regarding whether the defendants had been deliberately indifferent to Charette's serious medical needs. Nurse Bohlke rendered an opinion that the defendants were not deliberately indifferent based on: (1) the appropriateness of the treatment protocol; and (2) the fact that the denial of the liver biopsy did not cause Charette any damage. (Doc. No. 21, pp. 3-4; Doc. No. 25-4, p. 7; Doc. No. 27, p. 1) In a letter dated August 12, 2003, Nurse Bohlke stated, in relevant part:

> Liver biopsy is not necessary for diagnosis but helpful for grading the severity of the disease and staging the degree of fibrosis and permanent damage. Many doctors, but certainly not all doctors, do a liver biopsy whenever a client has a high ALT (alanine aminotransferase). [Charette] has had several ALT levels that have been elevated. His liver function labs were within the normal limits on February [7,] 2003 and April 21, 2003.
>
> . . . On July 10, 2000, it is noted that [Charette] does not fit the criteria for Hepatitis C treatment. To meet the criteria, it is noted that the ALT needs to be elevated for one year up to 300-500% of normal. On May 1, 2001, [Charette] demanded treatment for his Hepatitis C. [Charette] does not qualify for treatment according to the guidelines, which require 4-5 times normal on 2 occasions, at a minimum of 30 days apart, removed from baseline lab results. Normal values of the ALT are 1-60. There is a discrepancy in the chart about the criteria for Hepatitis C treatment, but [Charette] does not meet either criteria. [Charette] has had levels of 51 to 120 in the last two years, which at best is 2 times the normal value.
>
> On April 21, [2003, Charette's] physician writes that the UIHC (University of Iowa Hospital and Clinic) saw [Charette], and he had very different ALT results of 143, and at that time it was suggested that [Charette] have ultrasound and liver biopsy. A third protocol suggests that [Charette have] three (LFT) liver function tests and liver checks in six months, then

> average them to see if he qualifies with an average over 1.5 times normal (90). The LFTs should be rechecked on July 24, [2003] and October 22, [2003]. After [Charette] has lab work done in October, the decision will be made for treatment, if he qualifies. [Charette] did have an appointment to assess the need for a liver biopsy, and this was canceled. That doesn't mean that he won't have this done, it only means the guidelines are being used to assess the need for this treatment.

(Doc. No. 21, pp. 3-4; Doc. No. 25-4, p. 7)

On October 2, 2003, Charette filed a report to the court (Doc. No. 27) indicating he had learned, through discovery, that the DOC and the UIHC had developed a particular protocol to be used in all Hepatitis C cases within the Iowa prison system. Charette asked the court for permission to retain an additional expert to review his medical records and the DOC's Hepatitis C protocol that was utilized in his case, to determine whether the protocol passed constitutional muster. (Doc. No. 27, p. 4)

Dr. Duffy retired on September 12, 2003. (Doc. No. 25-3, p. 2) On October 6, 2003, the court granted Charette's request to retain an additional expert. (Doc. No. 29, p.1) Charette completed his sentence on January 23, 2004, and was discharged from custody. (Doc. No. 39-4, p. 1; Doc. No. 48-2, p. 1)

Charette then consulted Dr. Greg Kane, an internal medicine specialist from Colorado, seeking his expert medical opinion regarding Charette's claim that the defendants were deliberately indifferent to his serious medical need. Dr. Kane rendered an opinion that the DOC was deliberately indifferent when it: (1) refused to refer Charette to the UIHC for evaluation and treatment of his Hepatitis C infection from 1999 to 2002; and (2) failed to comply with protocol by rescinding the recommended Hepatitis C testing and treatment from 2003 to date. (*See* Doc. No. 39-4, p. 9-14) In a letter dated February 16, 2004, Dr. Kane stated as follows, in relevant part:

Between 1999 and into 2002, the Department of Corrections did blood tests to monitor Mr. Charette's ALT liver enzyme level. His enzyme levels were elevated, but the Department of Corrections refused referral for testing and treatment. The Department of Corrections based this refusal on a policy of referring patients only if their liver enzyme tests were "*4-5 times normal on two occasions at a minimum of 30 days apart removed from baseline lab* results." During this period, Mr. Charette's levels were between 1.7 and 3 times normal.

In 2002, the Department of Corrections allowed Mr. Charette to be seen by a liver specialist at the U of Iowa. The liver specialist recommended testing (liver biopsy), and hepatitis C treatment to be guided by the results of the biopsy. The Department of Corrections then refused the recommended biopsy, refused the recommended treatment and canceled the referral to the liver specialist. They based this refusal on a single normal liver enzyme level.

. . .

In people with hepatitis C infection, elevations of liver enzymes above normal levels are often a sign of serious active hepatitis infection. Even minor elevations of 1.5 times normal may be medically significant. Standard medical practice in the United States from 1999 into 2002 was for hepatitis C infected people with even "minor" liver enzyme elevations to have liver biopsies and, when indicated by the biopsy, treatment that is potentially life saving.

The Iowa Department of Corrections "old" protocol under which inmates were referred only if their liver enzymes were *4-5 times normal* [!] has no basis in medicine. I mean, there is no basis in medicine to deny care to people with liver enzyme elevations in the 1.5 to 4 (or is it 5?–the protocol is unclear) range.

. . .

. . . There are multiple guidelines published recommending when to biopsy people with hepatitis C infection. I am aware (and I've bolstered my opinion by searching the medical literature) of no guideline issued by any medical organization that recommends withholding biopsy in patients with enzyme elevations in the 2-5 times normal range.

Between 1999 and into 2002 when Mr. Charette's liver enzymes were elevated at roughly twice normal, he had a medical condition that doctors generally knew was serious. The liver specialist to whom Mr. Charette was finally referred recommended a liver biopsy – confirming the serious medical need. Only the Department of Corrections' agent-physicians refused to acknowledge the fact.

Any layman, knowing these facts, would easily recognize Mr. Charette's condition as one needing a liver doctor's attention.

Between 1999 and into 2002 Mr. Charette did have a serious medical need that created an excessive risk to his health.

. . .

Mr. Charette's Department of Corrections medical records confirm the Department of Corrections knew Mr. Charette suffers from hepatitis C infection, and that the Department of Corrections knew his liver enzymes were elevated. The Department of Corrections must have known such enzyme elevations reflected a serious medical need -- they had staff medical doctors advising them; further, in writing up their referral protocol they must have researched the basic medical facts.

Between 1999 and into 2002, the Department of Corrections refused Mr. Charette's repeated requests to have his hepatitis C infection evaluated and treated by a liver specialist -- it failed to act on it's [sic] knowledge of his serious medical need.

Between 1999 and into 2002, the Department of Corrections did know Mr. Charette had a serious medical condition that

created an excessive risk to his health, and the Department of Corrections failed to act on that knowledge. Between 1999 and into 2002 the Department of Corrections did act with deliberate indifference.

. . .

In 2002, Mr. Charette was seen by a liver specialist at the University of Iowa. That liver specialist recommended testing to be followed by treatment. It is this testing and treatment -- recommended by a University of Iowa physician, of a serious medical condition diagnosed by the University of Iowa physician -- that the Department of Corrections is now denying Mr. Charette.

. . .

The Department of Corrections has retested Mr. Charette's blood, found a "normal" liver enzyme level, and rescinded his liver specialist referral, testing and treatment.

There is no basis in medicine for this action. People with ongoing life-threatening liver damage from hepatitis C infection may have enzyme levels that fluctuate between normal and high. The medical question is not, "Are the levels high *today*?", the medical question is "Have they been high?"

The University of Iowa liver specialist has not rescinded his recommendation for biopsy and treatment.

The Department of Corrections' own "new" protocol calls for inmates to be referred to a liver specialist when their liver enzymes are 1.5 times normal on three occasion[s] over six months -- a condition Mr. Charette met. The protocol has no provision for repeat blood enzyme level testing. The protocol has no provision for denying the consulting specialist's prescribed testing and treatment based on repeat blood enzyme

> level testing. In denying Mr. Charette his liver biopsy and treatment the Department of Corrections is violating it's [sic] own protocol.
>
> . . .
>
> The medical purpose of the liver testing Mr. Charette has been denied is to find out exactly how far his chronic liver infection has progressed, and, as needed, to treat that infection. Such treatment may be life-saving. Of course without doing the testing he was and is being denied, it isn't possible to say exactly how much worse his condition is. Without testing, we may not know how serious his untreated disease is until he dies of the disease. At any rate it is now certain that Mr. Charette is at a higher risk of liver failure and death than he would have been had such testing and treatment been done.

(Doc. No. 52-2, pp. 1-6)[4]

In response, the defendants have submitted the affidavit of Dr. Doel dated July 2, 2004, in which the doctor states, in relevant part, as follows:

> In March 1997, the National Institute of Health (NIH) held a consensus development conference regarding the management and treatment of Hepatitis C viral infection. This led to an important, widely distributed NIH consensus statement, that, for several years, attempted to define and advise practitioners on management of care for Hepatitis C. The consensus statement, however, did not set forth a standard of care for Hepatitis C as no such agreed upon standard existed. Nonetheless, the Iowa Department of Corrections developed a management and treatment policy for Hepatitis C that was consistent with the 1997 NIH consensus statement. In June

[4]The court notes minor factual errors occur throughout Dr. Kane's letter. For example, he states that from 1999 to 2002, Charette's ALT levels were between 1.7 and 3 times normal, when the levels actually were between 1.07 and 2.97 times normal; and he states Charette was seen by a liver specialist, when he actually was seen by a physician's assistant at the UIHC. However, because Dr. Kane's opinion does not impact the final resolution of this case, the court finds the factual errors are not significant.

2002, the NIH held another conference on management of Hepatitis C as the knowledge and treatment options for Hepatitis C had increased dramatically. The final NIH statement with revisions was issued on September 12, 2002. Again, the NIH 2002 revisions did not set forth a medically accepted stand[ard] of care for Hepatitis C as no such agreed upon standard existed.

The Iowa Department of Corrections has a policy regarding the monitoring of and protocols for chronic disease. This policy includes provisions for Hepatitis C. The Iowa Department of Corrections has revised this policy as it relates to Hepatitis C to reflect the changing recommendations for the care of Hepatitis C. The Iowa Department of Corrections developed a management and treatment policy for Hepatitis C that was consistent with the 1997 NIH consensus statement as well as the September 12, 2002 NIH revisions. The Iowa Department of Corrections worked in conjunction with the University of Iowa Hospitals and Clinics (UIHC) Digestive Disease Department to develop a protocol for Hepatitis C. That protocol was instituted on January 16, 2003.

In 1999 Mr. Charette allowed Department of Corrections health staff to monitor and follow his disease process. Alanine Transaminases (ALT) values were monitored for the status of his liver function test. ALT values can sporadically be elevated due to a multitude of pathophysiologic reasons. However, of importance, are sustained liver enzymes. ALT is considered a sensitive marker of inflammation. Spurious rise in ALT values may be attributed to upper respiratory infection or alcohol use among other things. ALT levels do return to normal without any intervention. Consequently, one does not opt for or suggest a liver biopsy over a single elevation of ALT values without just cause. Hepatologist[s], Gastroenterologists and Infectious Disease Specialists agree with the notion of waiting to see if ALT levels persist prior to recommending an invasive procedure such as a liver biopsy. Almost all the protocols for Hepatitis C that have been

developed or published suggest to wait for 3 to 6 months before considering options for treatment. [Citations omitted.] This is an appropriate and acceptable non-invasive approach to Hepatitis C management since the virus was identified. As a result, the Iowa Department of Corrections formulated a policy for identification of candidates for Hepatitis C treatment in collaboration with the University of Iowa Hospitals and Clinics–Digestive Disease Department. This protocol is similar to protocols developed by other states as well as the Federal Bureau of Prisons. Inclusion criteria specify when a patient is referred for treatment.

. . . From 1999 to 2002, Iowa Department of Corrections policy recommendation[s] for referral were based on consistently elevated ALT values of 4-5 times normal on two occasions at a minimum of 30 days apart removed from the baseline results. This protocol was consistent with the 1997 NIH consensus statement. [Charette's ALT values from 1999 to 2002] show that [he] did not meet the eligibility criteria for referral for liver biopsy, i.e., there were no two ALT values taken at a minimum of 30 days apart which were 4-5 times normal range (60).

Starting on January 16, 2003, the Iowa Department of Corrections policy which set forth eligibility criteria was modified based on the NIH consensus statement revisions in collaboration with the University of Iowa Hospitals and Clinics-Digestive [D]isease [Department]. The January 2003 policy provided that to be recommended for referral, liver enzyme elevations needed to be greater than 1.5 times normal on three occasions over a 6 month period. . . . [Charette's ALT values from 2003] show a transient elevation of ALT above normal. At no time were the ALT values greater than 1.5 times normal on three occasions over a six-month period. Thus, Mr. Charette did not meet eligibility criteria for referral for liver biopsy.

The February 2003 recommendation of a Physician Assistant, at University of Iowa Hospitals and Clinic Liver Clinic, was

> a suggestion and not a standard of care. Most of the data published concerning management of Hepatitis C suggested to measure ALT levels prior to biopsy for an extended period of time. Mr. Charette's levels did not meet the recommendation for referral for treatment let alone a liver biopsy. . . . Invasive procedures such as biopsy have a risk for morbidity and mortality that is small but still present. There was no benefit to Mr. Charette to subject him to a biopsy in May of 2003. He did not meet the criteria for treatment according to the Iowa Department of Corrections policy or other published guidelines. [Citations omitted.].

(Doc. No. 48-2, pp. 4-8)

In addition to Dr. Deol's opinion, the defendants consulted Dr. Warren Schmidt, M.D., Ph.D., an Associate Professor of Medicine on staff at the UIHC and Chief of GI/Hepatology at the V.A. Medical Center in Iowa City, and asked for his expert medical opinion regarding Charette's care. Dr. Schmidt gave the following background regarding the Hepatitis C Virus:

> Hepatitis C virus is the most recently discovered of the major viruses that cause human liver disease, being identified and isolated only in 1989. Thus, standards of care for patient evaluation, management, and treatment with antiviral therapy have been in development for only a short time period as compared to other liver diseases. Consequently, universal guidelines for appropriate long term care and when to initiate intervention with antiviral therapy have been in a state of constant revision since the virus'[s] discovery.
>
> Approximately 80% of patients exposed to the HCV develop persistent infection of the liver. However, infection of the liver does not guarantee progressive liver disease. Only about 10-20% of infected patients develop serious liver disease that can lead to cirrhosis and liver cancer. Disease progression is slow and normally occurs over a period greater than 20 years. Progression is also critically dependent on

other patient risks such as age, alcohol consumption, and comorbid diseases such as diabetes and obesity. Consequently, HCV positivity cannot be tacitly assumed to present a serious medical need. The most important serum enzyme test for monitoring the disease progression is the ALT that is a marker for liver inflammation. It must be emphasized however, that while elevated ALT enzymes suggest hepatic HCV activity, they do not indicate the severity of liver disease nor the long-term patient prognosis. This is dependent on patient physical exam, other laboratory chemistries, and tests of liver synthetic function such as the serum albumin that are all considered in the clinical context of the case. It is not at all uncommon for patients with elevated ALTs to have none or minimal liver disease.

Prior to 1999, treatment of chronic HCV infection employed conventional interferon therapy in some patients that only led to long-term eradication of the virus in less than 10% of patients provided the therapy. In 1999 combination therapy with interferon and ribavirin was introduced which produced more successful long term treatment outcomes in about 40% of patients treated. Consideration for antiviral therapy is a decision made by the practitioner after clinical staging to determine whether a patient has progressive disease or fibrosis (liver scarring). Prior to antiviral therapy, patients are frequently monitored clinically with serial liver tests to roughly assess HCV activity in the liver. A decision for treatment of HCV with interferon therapy must carefully balance the risks to the patient with the probability of response. This is because interferon therapy is associated with severe side effects that include depression, blood cell abnormalities, and constitutional signs such as fever, malaise, and arthritis. Ten to 20% of patients started on antiviral therapy discontinue because of side effects. Depression due to interferon is also associated with an

> elevated risk for suicide. Consequently treatment candidates require careful clinical selection and monitoring before a decision for therapy is reached.

(*Id.*, pp. 10-11)

Dr. Schmidt rendered an opinion that the Iowa DOC provided Charette with reasonable and adequate medical care for his Hepatitis C during Charette's incarceration from 1995 to 2004. (*See* Doc. No. 48-2, pp. 10-14) In an opinion letter dated July 2, 2004, Dr. Schmidt noted that at the time Charettes was scheduled for his first liver retesting six months into his period of incarceration, he refused further evaluation. After he rescinded that decision in December 1999, the DOC institutions monitored him faithfully between 1999 and 2003. Dr. Schmidt summarized his findings as follows:

> At no time [during his incarceration] did [Charette] show serious medical signs that his HCV infection was leading to worsening liver disease and he never developed jaundice or liver failure. During this period, tests of liver synthetic function (albumin) were normal. His platelet level, a fairly reliable indicator for cirrhosis in Hepatitis C patients, was consistently normal. The ALT determinations showed elevations of 1 to 4 times normal.
>
> Mr. Charette was not referred for evaluation by a liver specialist prior to 2002 because of the existing institutional protocol that stated ALT elevations needed to be 2 to 4-5 times normal over a minimum of 30 days apart. This institutional protocol was consistent with the then recognized standard of medical care. This rationale was explained to Mr. Charette several times as documented in the notes. Mr. Charette filed grievances within the Iowa Department of Corrections concerning the lack of referral to a liver specialist that were denied. He sought legal advice from the Clinical Law Program at the University of Iowa for help in getting him sent for "proper medical testing, treatment, and care." The Clinical Law Program communicated with Dr. Deol, the

Medical Director of the Iowa Department of Corrections, in August of 2002 in a letter that listed elevated ALT values from 1999 to 2001. The letter stated that Mr. Charette was seeking "appropriate evaluation and treatment" and requested that Mr. Charette be evaluated at the University of Iowa Hospitals and Clinics. It is unclear how the Clinical Law Office formulated a medical opinion to make this request.

Nonetheless, in February of 2003 Mr. Charette was evaluated in the Liver Clinic at the University of Iowa. There, routine evaluation showed elevated transaminases (AST and ALT), however, tests of synthetic liver function were again normal and Mr. Charette also had normal platelet counts. There was no liver or spleen enlargement documented on physical exam and no peripheral signs of liver disease such as palmar erythema or spider angiomata. Thus, clinical evaluation did not find evidence of advanced liver disease. Nevertheless, a liver biopsy and ultrasound imaging were scheduled for May of 2003. However, repeat liver tests at the Iowa Department of Corrections facility in April 2003 were normal and the biopsy and imaging studies were canceled pending further evaluation. All liver tests performed thereafter (July and October of 2003) showed normal ALT values. Mr. Charette then discharged on January 23, 2004. Consequently, Mr. Charette was determined not to qualify for liver biopsy under the new protocol and this action was not contrary to current standards of clinical care for Hepatitis C.

. . .

There is no doubt that Mr. Charette has a potentially serious medical condition. However, what is essentially misunderstood by [Charette] and his counsel is the acuity of his hepatitis C evaluation and the urgency of management needs while he was incarcerated during the time period that he permitted evaluation, i.e., 1999-2003. During monitoring he never showed clinical signs of advanced liver disease, nor did he have physical examination signs of early cirrhosis such as liver and spleen enlargement, depressed levels of platelets or

other physical findings. Mr. Charette was faithfully monitored in the Iowa Department of Corrections from 1999-2003 with liver tests, blood counts, and physical exams. ALT values were sporadically elevated during this time, however, not at sustained periods to warrant referral to the University of Iowa Hospitals and Clinics Liver Clinic. Further, ALT values can not be used as a reliable, surrogate indicator for progressive liver disease from HCV. [Citations omitted.] At best, ALT values are weakly predictive of the long term effects of HCV[.] [Citations omitted.] While hepatologists do use ALT values to help make decisions for liver biopsy and antiviral therapy, these are invariably used together with physical exam findings and laboratory chemistries to make the best clinical decision. Consequently, it is not appropriate to use elevated ALT values . . . as a foundation for an argument that Mr. Charette has an urgent, serious medical need. Although Mr. Charette's biopsy was postponed, there is no reason to suspect that he has suffered medically from the delay. Considering that hepatitis C progresses to cirrhosis and end stage liver disease over a long period of 20-30 years, then the majority of evidence in his medical record strongly suggests that Mr. Charette's liver disease is at best slowly progressive. Ironically, institutionalization has probably had the greatest impact on Mr. Charette's disease progression as he did not have access to alcohol while incarcerated. Concurrent alcohol consumption is arguably the most important risk factor for disease progression due to chronic HCV[.] [Citation omitted.]

Mr. Charette alleges that he was denied "necessary medical care" in violation of his Eighth and Fourteenth Amendment Rights. Currently, the subject of "necessary medical care" is still in considerable dispute for HCV infection by hepatologists. As explained above, only about one fifth or less of people infected with Hepatitis C advance to cirrhosis and there are no universal guidelines for patient management and antiviral therapy for chronic HCV. Less than 30% of all HCV patients qualify medically and psychologically for antiviral therapy. The most reliable and up to date recommen-

dations for monitoring and treatment of chronic HCV infection can be found in the recent National Institutes of Health Consensus Development Conference Statement (2002). The recommendations in this document are not contrary to the care that Mr. Charette received. . . . Mr. Charette was not deprived of medical evaluation and during the time interval that he was monitored he did not suffer from an objective "serious medical need" which is necessary for violation of his Eighth Amendment Rights. The major issue appears to be that Mr. Charette did not have a liver biopsy while under Dr. Duffy's care. However, a biopsy has not been ruled out, and in fact is still available to Mr. Charette. Furthermore, Mr. Charette remains a potential treatment candidate. It is not appropriate to allege that the "delay" that he experienced while incarcerated is a denial of "necessary medical care"; as such a small delay is unlikely to change his overall clinical course. As explained above, the four-year interval over which he permitted evaluation is a small period of time in the long natural history of HCV infection and disease course.

Mr. Charette alleges that he was treated with "deliberate indifference" to his medical needs. In fact, the Iowa Department of Corrections had set a pioneer program in place early in the 1990s for monitoring HCV infected inmates and infectious disease protocols to prevent exposure to non-infected inmates. Since then, the Iowa Department of Corrections has worked closely with the liver clinic at the University of Iowa to provide up to date comprehensive management for HCV infected inmates. The Iowa Department of Corrections is to be congratulated for the development of new, reasonable guidelines for patient diagnosis, monitoring, and treatment as this is specifically recommended in the new NIH Consensus Document. . . . Most state and federal prisons have no such program and there are no universal screening and treatment recommendations for patients with HCV. Mr. Charette only permitted evaluation of his hepatitis over a less than 4 year interval of incarceration. He received adequate monitoring for HCV activity and the intermittent evaluations

> provide evidence that he had a stable liver condition during this time without the development of cirrhosis. Consequently, the medical care received by Mr. Charette can hardly be called "deliberate indifference" to his medical needs. In fact, Mr. Charette actually received better care and management for chronic HCV than many community practitioners provide to private patients.
>
> Mr. Charette also stated in his grievances that the Liver Clinic in Iowa City had determined that he had suffered liver damage from the disease. However, review of these medical records of February 7, 2003 showed no physical findings of liver disease, normal cellular blood counts, and the only abnormalities on the liver chemistries were abnormal transaminases. The statement "determine the extent of liver disease" in Mr. Charette's February, 2003 University of Iowa Liver Clinic evaluation doesn't mean that Mr. Charette has a "severe medical need". Nor should this be taken as an implied assumption of liver disease. It is quite possible that Mr. Charette has minimal or even no fibrosis. Consequently, the assumption of "severe liver disease" has in fact no evidence in his clinical and medical findings. It is clear that the treatment Mr. Charette received for his Hepatitis C positivity from the Iowa Department of Corrections from 1999 through January of 2004 met then acceptable medical standards and did not cause Mr. Charette any physical injury.

(Doc. No. 48-2, pp. 11-14)

The following table summarizes Charette's ALT or AST testing while he was committed to the custody and care of the Iowa DOC:

Date	Test	Charette's Level	Normal	Charette's Level x Normal	Lab
01/17/95	ALT	212 or 67	45 or 40	4.71 or 1.68	Quest or Corning
10/31/95	ALT	183	45	4.07	Quest or Corning
12/15/99	ALT	113	60	1.88	Quest
01/26/00	ALT	135	55	2.45	Quest
03/07/00	ALT	125	55	2.27	Quest
05/19/00	ALT	178	60	2.97	Quest
07/06/00	ALT	141	60	2.35	Quest
08/07/00	ALT	125	60	2.08	Quest
09/27/00	ALT	123	60	2.05	Quest
11/20/00	ALT	101	60	1.68	Quest
05/25/01	ALT	113	60	1.88	Quest
11/07/01	ALT	120	60	2.00	Quest
03/13/02	ALT	92	60	1.53	Quest[5]
10/22/02	ALT	64	60	1.07	Quest
02/07/03	ALT	143	35	4.09	Iowa
02/07/03	AST	66	37	1.78	Iowa
04/21/03	ALT	51	60	0.85	Quest
07/24/03	ALT	38	60	0.63	Quest

[5] Charette was incarcerated at the Anamosa State Penitentiary from March 16, 1995, to August 14, 2001, and from March 26, 2002, to January 23, 2004. The testing on November 7, 2001 and March 13, 2002, occurred while Charette was confined at the Mount Pleasant Correctional Facility.

Date	Test	Charette's Level	Normal	Charette's Level x Normal	Lab
10/07/03	ALT	39	60	0.65	N/A
10/13/03	ALT	46	60	0.77	N/A

(Doc. No. 39-3, p. 14; Doc. No. 39-4, p. 10; Doc. No. 48-2, p. 6-7)

IV. ANALYSIS

A. Charette's Eighth Amendment Claim

The Eighth Amendment to the United States Constitution provides that "[e]xcessive bail shall not be required, nor excessive fines imposed, nor cruel and unusual punishments inflicted." U.S. Const., amend. VIII. Accordingly, the treatment a prisoner receives in prison and the conditions of his confinement are subject to scrutiny under the Eighth Amendment. *Farmer v. Brennan*, 511 U.S. 825, 831-32, 114 S. Ct. 1970, 1976, 128 L. Ed. 2d 811 (1994); *Helling v. McKinney*, 509 U.S. 25, 31-32, 113 S. Ct. 2475, 2480, 125 L. Ed. 2d 22 (1993). In its prohibition of cruel and unusual punishments, the Eighth Amendment places a duty on jail and prison officials to provide inmates with necessary medical attention. *Wilson v. Seiter*, 501 U.S. 294, 303, 111 S. Ct. 2321, 2326-27, 115 L. Ed. 2d 271 (1991); *Weaver v. Clark*, 45 F.3d 1253, 1255 (8th Cir. 1995). In this context, a prison official violates the Eighth Amendment by being deliberately indifferent either to a prisoner's existing serious medical needs or to conditions posing a substantial risk of serious future harm. *Weaver*, 45 F.3d at 1255 (comparing *Estelle v. Gamble*, 429 U.S. 97, 104-105, 97 S. Ct. 285, 291, 50 L. Ed. 2d 251 (1976) (existing medical needs) with *Helling*, 509 U.S. at 33-34, 113 S. Ct. at 2480-81 (risk of future harm to health)).

An Eighth Amendment violation occurs only when two requirements are met: (1) "the deprivation alleged must be, objectively, 'sufficiently serious,'" and (2) the "prison

official must be, as a subjective state of mind, deliberately indifferent to the prisoner's health or safety." *Beyerbach v. Sears*, 49 F.3d 1324, 1326 (8th Cir. 1995) (citations omitted). *See also Helling*, 509 U.S. at 32, 113 S. Ct. at 2480; *Estelle*, 429 U.S. at 106, 97 S. Ct. at 292; *Williams v. Delo*, 49 F.3d 442, 445-47 (8th Cir. 1995). In the context of a prisoner's claim of inadequate medical care, society does not expect that prisoners will have unqualified access to health care. *Hudson v. McMillian*, 503 U.S. 1, 9, 112 S. Ct. 995, 1000, 117 L. Ed. 2d 156 (1992). Consequently, "deliberate indifference to medical needs amounts to an Eighth Amendment violation only if those needs are 'serious.'" *Id.* (citing *Estelle*, 429 U.S. at 103-04, 97 S. Ct. at 290). *See also Wilson*, 501 U.S. at 298, 111 S. Ct. at 2324.

To constitute an objectively serious medical need or a deprivation of that need, the need or the deprivation either must be supported by medical evidence or must be so obvious that a layperson would recognize the need for a doctor's attention. *Aswegan v. Henry*, 49 F.3d 461, 464 (8th Cir. 1995); *Johnson v. Busby*, 953 F.2d 349, 351 (8th Cir. 1991). *See, e.g., Beyerbach*, 49 F.3d at 1326-27 (insufficient evidence of objective seriousness when there is no medical evidence that delay in treatment produced any harm); *Kayser v. Caspari*, 16 F.3d 280, 281 (8th Cir. 1994) (insufficient evidence of serious medical need when the medical need claimed is based on bare assertion of inmate).

To meet the second requirement, the "subjective" component of an Eighth Amendment claim, a prison or jail official must have a "sufficiently culpable state of mind." *Wilson*, 501 U.S. at 297-303, 111 S. Ct. at 2323-26; *Hudson*, 503 U.S. at 8, 112 S. Ct. at 999. In a medical needs claim, that state of mind is one of "deliberate indifference" to inmate health. *Farmer*, 511 U.S. at 838-39, 114 S. Ct. at 1979-80; *Helling*, 509 U.S. at 32, 113 S. Ct. at 2480; *Wilson*, 501 U.S. at 302-303, 111 S. Ct. at

2326; *Estelle*, 429 U.S. at 106, 97 S. Ct. at 292. Regarding the meaning of the term "deliberate indifference," the United States Supreme Court has explained:

> [A] prison official cannot be held liable under the Eighth Amendment for denying an inmate humane conditions of confinement unless the official knows of and disregards an excessive risk to inmate health or safety; the official must both be aware of the facts from which the inference could be drawn that a substantial risk of serious harm exists, and he must also draw the inference. . . . The Eighth Amendment does not outlaw cruel and unusual "conditions"; it outlaws cruel and unusual "punishments."

Farmer, 511 U.S. at 837, 114 S. Ct. at 1979. Thus, to establish the second requirement, "deliberate indifference," a plaintiff must assert facts showing the defendant actually knew of and disregarded a substantial risk of serious harm to the plaintiff's health or safety. *Id.*, 511 U.S. at 840-47, 114 S. Ct. at 1980-84; *Helling*, 509 U.S. at 32, 113 S. Ct. at 2480.

Medical treatment that displays "deliberate indifference" violates the Eighth Amendment "whether the indifference is manifested by prison doctors in their response to the prisoner's needs or by prison guards in intentionally denying or delaying access to medical care or intentionally interfering with the treatment once prescribed." *Estelle*, 429 U.S. at 104-05, 97 S. Ct. at 291. *See also Foulks v. Cole County*, 991 F.2d 454, 456-57 (8th Cir. 1993). Negligent acts by prison officials, however, are not actionable under 42 U.S.C. section 1983. *See Davidson v. Cannon*, 474 U.S. 344, 347-48, 106 S. Ct. 668, 670, 88 L. Ed. 2d 677 (1986); *Daniels v. Williams*, 474 U.S. 327, 333-34, 106 S. Ct. 662, 666, 88 L. Ed. 2d 662 (1986); *Estelle*, 429 U.S. at 106, 97 S. Ct. at 292; *Taylor v. Bowers*, 966 F.2d 417, 421 (8th Cir. 1992). Further, an inmate's disagreement or displeasure with his course of medical treatment is not actionable under 42 U.S.C. § 1983. *Bellecourt v. United States*, 994 F.2d 427, 431 (8th Cir. 1993); *Davis v. Hall*, 992 F.2d 151, 153 (8th Cir. 1993) (per curiam); *Warren v. Fanning*, 950 F.2d 1370, 1373 (8th Cir.

1991); *Smith v. Marcantonio*, 910 F.2d 500, 502 (8th Cir. 1990); *Givens v. Jones*, 900 F.2d 1229, 1233 (8th Cir. 1990).

In the present case, Charette claims the defendants acted with deliberate indifference to his serious medical needs. For purposes of considering the defendants' motion for summary judgment, the court will accept, without deciding, that Charette's Hepatitis C condition constituted a serious medical need during his incarceration. Charette generally disapproves of the course of medical treatment he received for his Hepatitis C. More specifically, Charette objects to the defendants' utilization of two separate protocols -- an "old protocol" and a "new protocol" -- to (1) monitor his Hepatitis C status from 1999 to 2004, (2) refuse his referral requests, and (c) cancel his recommended biopsy and ultrasound.[6]

Charette's dissatisfaction with the course of his medical treatment does not give rise to a viable Eighth Amendment claim. *See Taylor v. Norris*, 36 Fed. Appx. 228, 229, 2002 U.S. App. LEXIS 11269, 2002 WL 1273649 (8th Cir. 2002) (deliberate indifference claim failed when it boiled down to a disagreement over recommended treatment for hernias and decision not to schedule a doctor's appointment); *Abdul-Wadood v. Nathan*, 91 F.3d 1023, 1024-35 (7th Cir. 1996) (inmate's disagreement with selection of medicine and therapy for sickle cell anemia falls well short of demonstrating deliberate indifference); *Sherrer v. Stephen*, 50 F.3d 496, 497 (8th Cir. 1994) (inmate's "desire for a replacement joint instead of fusion surgery is merely a disagreement with the course of medical treatment and does not state a constitutional claim"); *Kayser v. Caspari*, 16 F.3d 280, 281 (8th Cir. 1994)

---

[6] The court notes Charette cites one case --*Burke v. N.D. Dep't of Corr. & Rehab.*, 294 F.3d 1043 (8th Cir. 2002) -- in support of his argument that the defendants were deliberately indifferent and summary judgment is inappropriate. However, *Burke* does nothing to bolster Charette's position because the court merely reversed a district court's initial review determination, not a summary judgment determination. *See id*.

(prison provided escalating level of treatment for inmates's ailments over time, and inmate's disagreement with course of medical treatment was insufficient basis for Eighth Amendment violation); *Czajka v. Caspari*, 995 F.2d 870, 871 (8th Cir. 1993) (inmate's mere disagreement with doctor's informed decision to delay surgery does not establish Eighth Amendment claim); *Smith v. Marcantonio*, 910 F.2d 500, 502 (8th Cir. 1990) (inmate failed to prove deliberate indifference where his complaints represented nothing more than mere disagreement with course of his medical treatment); *Lair v. Oglesby*, 859 F.2d 605, 606 (8th Cir. 1988) (disagreement about whether doctor should have prescribed medication does not result in constitutional violation); *Martin v. Sargent*, 780 F.2d 1334, 1339 (8th Cir. 1985) (inmate failed to state facts indicating doctor deliberately disregarded his medical problem; inmate's disagreement as to proper medical treatment does not give rise to Eighth Amendment violation). The record indicates the protocol for treating Hepatitis C is continuing to evolve. Nothing in the record suggests a referral or biopsy is necessary for proper treatment in every case, and there is no evidence that the course of treatment adopted by the defendants deviated from the standard medical practice. Prison health officials are given great latitude in formulating treatment plans, and differences of opinion, as a matter of law, do not amount to a constitutional violation. *Id.*

Charette admits that from 1999 to 2002, the defendants monitored his Hepatitis C utilizing the "old protocol" that required his liver enzyme tests to be 4 to 5 times normal on two occasions at a minimum of thirty days apart removed from baseline lab results. The summary judgment record pertaining to those years indicates the defendants tested Charette on twelve separate occasions, he had an average ALT of 2.02 times normal, and his ALT values never reached 3 times normal during that time period. Given his ALT values, Charette did not qualify under the "old protocol" for a referral. Similarly, Charette admits the defendants utilized, in 2003, a "new protocol" that required his liver

enzyme tests to be 1.5 times normal on three occasions over a six-month period (initial abnormal lab, then at three and six months). The record indicates Charette underwent testing on five separate occasions during 2003. He had an ALT of 4.09 times normal on February 7, 2003, but thereafter, his ALT levels consistently remained less than 1 times normal (average ALT of 0.73 times normal). Given these ALT values, Charette did not qualify under the "new protocol" for a referral to the Hepatitis C Committee for treatment recommendations.

Charette argues the defendants disregarded his serious medical needs by following the "old protocol" developed by the Iowa DOC and the UIHC. To support his argument, Charette offers Dr. Kane's opinion that the defendants were deliberately indifferent when they refused, per the "old protocol," to refer Charette to the UIHC for evaluation and treatment from 1999 to 2002. However, Dr. Kane merely offers conclusory and unsupported statements in his letter which are insufficient to create a factual dispute that the defendants were deliberately indifferent to Charette's serious medical needs. *See Dulany v. Carnahan*, 132 F.3d 1234, 1242-43 (8th Cir. 1997) (expert's unsupported opinion is insufficient to create factual dispute that prison officials failed to respond reasonably to inmate's serious medical needs); *Miller v. Citizens Sec. Group, Inc.*, 116 F.3d 343, 346 (8th Cir. 1997) ("A conclusory statement in an affidavit, however, cannot create a genuine issue of material fact which precludes summary judgment."). Dr. Kane cited no authority indicating it was inappropriate to follow the "old protocol," or would have been appropriate to refer Charette to a specialist based solely on his ALT test results (*i.e.*, an average ALT of 2.02 times normal) from 1999 to 2002.

Further, it is unclear how the defendants could be deliberately indifferent to Charette's serious medical needs if they were following a protocol developed in conjunction with the UIHC, a highly-regarded institution that remains on the cutting edge

of innovations in the treatment of Hepatitis C and other diseases. Charette does not argue the defendants knew their "old protocol" fell below the standard of care recommended by other authorities specializing in the treatment of Hepatitis C. Even the National Institutes of Health did not set forth a standard of care for Hepatitis C in its 1997 Consensus Statement, because no such agreed-upon standard existed. *See* National Institutes of Health Consensus Statement, Management of Hepatitis C, http://consensus.nih.gov/cons/105/105_statement.pdf (1997). Given the state of knowledge regarding Hepatitis C and its treatment during the period in question, the court finds it was reasonable and appropriate for the DOC to utilize the protocol it had developed with the UIHC's assistance. Thus, the court concludes Charette has failed to provide evidence from which a trier of fact could draw an inference that his medical treatment from 1999 to 2002 was so inappropriate as to prove intentional maltreatment or a refusal to provide essential care. *See Smith v. Jenkins*, 919 F.2d 90, 93 (8th Cir. 1990).

Dr. Kane further asserts the defendants failed to follow the "new protocol"; however, he offers no explanation for this conclusion and the record contradicts his assertion. Charette's medical records clearly indicate the defendants properly utilized the "new protocol" after January 16, 2003; that is, they determined Charette's ALT levels were not 1.5 times normal on three occasions over a six-month period following February 7, 2003, the date his ALT level was 4.09.[7] The same medical records undermine Dr. Kane's assertion that the defendants relied on a single normal test to cancel

[7] Based on his statement that what matters is whether Charette's ALT levels ever have been high, it appears Dr. Kane's position is the "new policy" should have been applied to Charette's entire medical history; that is, Dr. Kane argues the court should look at Charette's records from 1995 to 2002, and apply the "new policy" to them. Dr. Kane offers no authority to support this argument. Furthermore, his position is contrary to the general tenets of health care, and ignores the fact that from December of 1999 to October of 2003, Charette's ALT values were dropping consistently.

the scheduled ultrasound and biopsy. Dr. Duffy's medical notes indicate that in deciding to cancel the biopsy and ultrasound, he (1) reviewed Charette's medical history, (2) consulted with Dr. Doel, who advised him to follow the protocol, and (3) relied on Charette's test results from March 13 and October 22, 2002, and February 7 and April 21, 2003. All the evidence in the record indicates the defendants complied with the "new protocol" when they cancelled the ultrasound and biopsy. None of Charette's evidence, including Dr. Kane's letter, establishes the defendants actually knew of and deliberately disregarded Charette's serious medical need in 2003.

Charette makes much of the fact that the defendants failed to follow the recommendation of PA Stephanie Dee. Dr. Duffy considered PA Dee's recommendation, but decided to follow the advice of Dr. Deol. Although he canceled the ultrasound and biopsy, Dr. Duffy did so in light of Charette's more recent test results, Dr. Deol's advice, and the DOC's "new protocol." His considered decision fails to show he deliberately disregarded Charette's serious medical needs. *See Davis v. Norris*, 198 F.3d 249, 249 (8th Cir. 1999) (no constitutional violation where record, viewed most favorably to inmate, shows only a disagreement over a particular type of dental procedure; that is, one examining dentist recommended a root canal and another recommended extraction); *Vaughan v. Lacey*, 49 F.3d 1344, 1346 (8th Cir. 1995) (doctors' "disagreement as to the proper course of [a prisoner's psychiatric] treatment [is] not actionable under the Eighth Amendment"); *Czajka v. Caspari*, 995 F.2d 870, 871 (8th Cir. 1993) (rejecting inmate's argument that treating doctor was bound by opinion of another doctor who believed surgery was required; treating doctor had final authority and there was no evidence indicating decision to delay surgery so deviated from professional standards that it amounted to deliberate indifference); *Sanchez v. Vild*, 891 F.2d 240, 242 (9th Cir. 1989) (inmate's allegation that prison doctors failed to treat him properly where another doctor

advised surgery did not amount to deliberate indifference); *Christy v. Robinson*, 216 F. Supp. 2d 398, 414-17 (D.N.J. 2002) (difference of medical opinion regarding inmates' treatment for Hepatitis C positivity and necessity of liver biopsy does not constitute constitutional violation). On the contrary, Dr. Duffy's actions indicate he exercised his own medical judgment when assessing Charette's condition. The defendants have provided ample medical evidence to show their chosen course of treatment was based on sound medical judgment. In addition, Charette has offered no evidence to indicate the denial of his request for a referral and a liver biopsy was motivated by inappropriate, non-medical reasons.

The objective portion of the deliberate indifference standard requires a showing of verifiable medical evidence that the defendants ignored an acute or escalating situation, or that delays adversely affected the prognosis given the type of medical condition present in the case. *See Dulany v. Carnahan*, 132 F.3d 1234, 1243 (8th Cir. 1997) (citing *Crowley v. Hedgepeth*, 109 F.3d 500, 502 (8th Cir. 1997), and *Beyerbach*, 49 F.3d at 1326). *See also O'Neil v. White*, 221 F.3d 1343, 1343 (8th Cir. 2000) (citing *Crowley*, 109 F.3d at 502). Charette has presented no verifiable medical evidence to indicate that the delay in getting a referral or a liver biopsy has affected his prognosis adversely.

In sum, the Constitution does not guarantee that a prisoner is entitled to receive every type of treatment he desires, or even that may be beneficial to his condition. As the Eighth Circuit has observed, "prisoners do not have a constitutional right to any particular type of treatment," and "[p]rison officials do not violate the Eighth Amendment when, in the exercise of their professional judgment, they refuse to implement a prisoner's requested course of treatment." *Long v. Nix*, 86 F.3d 761, 765 (8th Cir. 1996). Charette has offered no evidence that the defendants deliberately disregarded his serious medical needs. *Cf. Rodriguez v. Bakke*, 84 Fed. Appx. 685, 687-88, 2003 U.S. App. LEXIS 26304, 2003

WL 23095523 (7th Cir. 2002) (finding no deliberate indifference where evidence does not indicate defendants chose a course of care they knew was ineffective or disregarded the needs of inmate with Hepatitis C); *Prater v. Dep't of Corrections*, 11 Fed. Appx. 668, 669, 2001 U.S. App. LEXIS 6569, 2001 WL 370476 (8th Cir. 2001) (inmate's allegations did not state constitutional claim because he did not allege medical staff denied, delayed, or refused him treatment, only that they did not order X-rays, provide him boots rather than insoles, or refer him to a specialist); *Dulany*, 132 F.3d at 1240-44 (plaintiffs did not present evidence that course of treatment, or lack thereof, so deviated from professional standards that it amounted to deliberate indifference); *Long*, 86 F.3d at 765 (inmate failed to show deliberate indifference even though inmate's expert recommended a different course of treatment); *Sherrer v. Stephen*, 50 F.3d 496, 497 (8th Cir. 1994) ("While the course of treatment was conservative, [inmate's] allegations do not rise to the level of deliberate indifference."). Indeed, the undisputed evidence establishes the defendants conducted all the monitoring and tests required by protocol when responding to Charette's Hepatitis C.

After drawing all reasonable inferences in favor of Charette, the court concludes the evidence fails, as a matter of law, to demonstrate the type of deliberate indifference necessary to establish a violation of the Eighth Amendment. Because the evidence fails to establish deliberate indifference by the defendants, it is appropriate to grant the defendants' motion for summary judgment.

B. The Defendants' Other Grounds for Summary Judgment

Having concluded Charette's Eighth Amendment claim fails as a matter of law, the court does need to review the defendants' assertions that 42 U.S.C. § 1997e(e) bars Charette's claim, or that they are entitled to qualified immunity. Similarly, the court

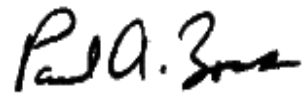
declines to review the defendants' assertion that Charette's requests for declaratory and injunctive relief are moot.

V. CONCLUSION

For the foregoing reasons, **IT IS RECOMMENDED** that, unless any party files objections[8] to the report and recommendation in accordance with 28 U.S.C. § 636(b)(1)(C) and Fed. R. Civ. P. 72(b) within ten (10) days of the service of a copy of this report and recommendation, the defendants' motion for summary judgment be granted, and judgment be entered in favor of the defendants and against Charette.

IT IS SO ORDERED.

DATED this 4th day of August, 2004.



PAUL A. ZOSS
MAGISTRATE JUDGE
UNITED STATES DISTRICT COURT

[8] The parties must specify the parts of the report and recommendation to which objections are made. In addition, the parties must specify the parts of the record, including exhibits and transcript lines, which form the basis for such objections. *See* Fed. R. Civ. P. 72. Failure to file timely objections may result in waiver of the right to appeal questions of fact. *See Thomas v. Arn*, 474 U.S. 140, 155, 106 S. Ct. 466, 475, 88 L. Ed. 2d 435 (1985); *Thompson v. Nix*, 897 F.2d 356, 357-58 (8th Cir. 1990).